DOCUMENT RESUME

ED 340 948 CG 023 903

AUTHOR Schneider, Lawrence J.
TITLE Ethics Education for the Family Psychologist: Who Is the Client?
PUB DATE Aug 91
NOTE 18p.; Paper presented at the Annual Convention of the American Psychological Association (99th, San Francisco, CA, August 16-20, 1991).
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Counselor Attitudes; *Counselor Characteristics; Counselor Client Relationship; *Counselors; *Counselor Training; *Ethics; *Family Counseling

ABSTRACT

W. G. Perry (1970) formulated a description of stages of intellectual and ethical development. Perry's schema seems to have applicability in describing trainees as they approach working with families and gauging counselor trainees' level of progress. The first stage is "dualism" in which trainees rely primarily on the use of logic and the weight of authority and experts' opinions to build a base of support for arriving at the right answer. In the second stage, called "multiplicity," trainees realize that the most important questions raised in family therapy have no "right or wrong" answers and they begin to perceive a high degree of relativism. In the third stage, "committed relativism," trainees who begin to sense what stage three is about possess more intrinsic interest in family therapy, are more aware of ramifications of therapists' interventions, appear to have greater awareness of ethical issues involved in working with families, have a greater sense of confidence in their skills, and display an attitude that they do not necessary know what is best for the family in treatment. The 1980s and 1990s seem to be witnessing increased awareness of ethical issues among family psychologists due to factors related to the legal professions and training programs. Failing to develop ethically binds and constricts the therapist's efficacy and potential to help the client and the client's family relations. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED340948

Ethics Education for the Family Psychologist: Who Is the Client?

Lawrence J. Schneider
University of North Texas
Psychology Department
Denton, TX 76203-3587

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Lawrence J. Schneider

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CG023903

Presented at the American Psychological Association, August, 1991, San Francisco, CA.

BEST COPY AVAILABLE

Ethics Education for the Family Psychologist: Who Is the Patient?

I had a bit of difficulty thinking about what to say today. Just how does one educate and assist trainees in the delivery of ethical family therapy? Is requiring trainees to read the literature about ethics in family therapy enough? Only a few textbooks attend in exclusive or major ways to ethical issues in family therapy (e.g., Huber & Baruth, 1987). The American Psychological Association's (APA, 1990) Ethical Principles have not directly addressed issues in dealing with families. However, the June, 1991, draft revision of the APA Principles (APA, 1991) acknowledges ethical issues involved in working with families as multiple client situations (see Principle 4, Therapeutic Relationships). Other professional groups (e.g., American Association for Marriage and Family Therapy, AAMFT) have perhaps been more actively involved in efforts to codify ethics for family therapists (AAMFT, 1991). Just what is contained in the literature regarding the ethics of family therapy? Are the ethics of treating families really distinct?

Each year I watch as fledgling trainees commence their training programs with trepidation, concerned that they will not measure up to standard, feeling that they stand inferior to advanced trainees, pre-occupied to do everything by the book less they be in technical violation of any administrative policy at

the training site, fearing that failure to establish a regular caseload will reflect inability to meet training program expectations, and striving to divine what their supervisors (such as myself) expect so that they will be able to obtain a favorable training evaluation. I ponder several questions: in such a climate can this counselor be trained? . . . by me? how can trainers assure the welfare of the families treated by the trainee who is trying to become comfortable with and skilled in the craft of family therapy?

What I would like to do today is lay out a description of stages of intellectual and ethical development formulated by Perry (1970) and then relate incidents illustration two of those stages. William Perry formulated a description of stages of intellectual and ethical development based on observations of Harvard male undergraduates' reactions to the intellectual life of the institution. (Blenky et al., 1986, have suggested that Perry's schema may not give a complete account of the intellectual development of women.) Perry's schema seems to have applicability in describing trainees as they approach working with families and gauging trainees' level of progress. Perry's schema consists of three stages: dualism, multiplicity, and relativism. As preface comment, it is important to be mindful of generalizations inherently applicable to most stage formulations. First, progression to later stages is based on successfully negotiating one's way through the earlier stages;

second, individuals do not necessarily progress in orderly fashion through the various levels; and, third, individuals probably move back and forth among the stages. Trainees make progress and have relapses as they move through their training (and sometimes in ongoing work with the same family case). Let us turn to consideration of Perry's stages.

Stage 1: Dualism

As individuals face a new task requiring use of intellectual skills and determining ethical courses of action, they bring to bear their past mode of approach to problem solving. Typically this involves finding the "correct" answer or ferreting out the ethically sanctioned course of action. One sees trainees trying to determine what the right and wrong answers are. At this point, trainees rely primarily on the use of logic and the weight of authority and experts' opinion to build a base of support for arriving at the right answer.

In this stage the beginning trainee seems vulnerable. Trainees' base of support is often built on the limits of their academic preparation; the depth of their exposure to ethical codes (APA, 1990) and guidelines for providers (APA, 1981, 1987); and their prior experience in applied work. Trainees at this stage are prone to construe codes and guidelines concretely, assume consensual agreement exists regarding ethical codes, and interpret ethical principles literally. (Ryder and Hepworth, 1990, provide good illustrations of the pitfalls of such an orientation.) The academic preparation of stage one trainees

could be characterized as lacking a broad enough base, their understanding and their interpretation of ethical codes as too literal, and the range of their experience with problems and issues brought to therapy as limited. While one can sometimes admire the enthusiasm of new trainees, their eagerness can also be frightening.

Stage 2: Multiplicity

It generally takes some time to start the transition from stage one (dualism) to stage two (multiplicity). Trainees have considerable commitment to their prior learnings and knowledge. It is a difficult struggle for them to abandon reliance on prior authoritative sources and to discontinue searching for the "right" answer. As trainees negotiate this separation, realization sets in that the most important questions raised in family therapy have no "right or wrong" answers. Trainees begin to perceive a high degree of relativism. This realization forces adoption of a new perspective that often challenges their former way of dealing with ethical and moral issues. Simple logic and resorting to authority no longer works and the trainee must face the prospect that there is no one "right" answer. Many ways of adaptation to the problems of the family are possible. No particular resolution may possess greater desirability in an absolute sense, some outcomes seem more desirable only when one is considering the perspective of a particular family member (or that of the therapist).

Trainees begin to understand that solving important

questions they face in therapy often depends upon the assumptions they start with. For example, trainees may adhere to the belief that dual relationships are unethical. But trainees step out to skate on the thin ice of uncertainty when they start asking themselves the difficult questions concerning how to apply such ethical beliefs. In applying the dual relationship tenet, how will the trainee react to learning after some way into family treatment that the spouses have different agendas? For example, the parents in the family decide to divorce and each wants custody of the children. The husband requests the therapist to testify on his behalf, while the wife wants the therapist to maintain confidentiality concerning the sessions.

In stage two trainees often feel an undermining of their previously held moral and ethical concepts. Frequently trainees experience a crisis as a response to abandoning previous methods of dealing with patients' emotional issues and the ramifications for the patient's family. In grappling with relativistic views of ethics and issues, trainees' own identity and confidence may be called into question. Trainees often feel less certain how to proceed, may relapse into greater dependence on supervisors' suggestions and opinions, and attach themselves to therapy styles that provide specific and concrete techniques. Some trainees are at risk of regressing to the earlier stage of dualism. Witnessing replays of destructive interactional family patterns can prompt in the trainee a sense of urgency to interdict and alter the situation in some way (Greenberg, 1983; Lakin, 1991).

The appeal of charismatic styles of intervention is strong when dealing with families and their issues that are difficult to control, contain, or direct. Some trainees are likely to resort to shopping lists of family concepts and techniques. The trainee may experience a feeling of having done something therapeutic if he or she can paradox someone, create a structural shift, or detriangulate a family member. In grappling with the family as a multiperson system, at stage two the trainee may be struggling to keep in charge. Doing something--using any technique--is better than doing nothing at all.

Some trainees experience the task of family therapy as overwhelming and opt to abandon working with families. An adaptive step that some trainees elect involves deciding to seek their own therapy. Many find this helpful in clarifying personal issues that frequently involve considering experiences in their own families.

Stage 3: Committed Relativism

I re-label Perry's third stage as committed relativism. The challenge for the neonate family therapist at this point is to move beyond the simple relativism of the prior stage to a point where the trainee makes the willing choice to live with ambiguity. The most important issues in therapy have a relativistic component. There are innumerable ways to compromise polar points of view. Each family member represents a perspective on the family's problems and makes the case for what he or she considers the workable solution to the family's

difficulty. As a participant in the family's therapy, the trainee presents yet another perspective and potential solution. Trainees' skill in compromising their own priorities is essential in helping the family systems identify priorities is essential. Despite trainees's personal or professional perspective on the optimal resolution of the family's problem(s), the family trainee often learns to settle for less than what he/she considers a desirable accommodation for this family.

When the family achieves a solution for its problems that is satisfactory, the family will proceed to termination of treatment. Whether or not in complete accord with the family's solutions, the trainee accepts them in the context that no resolutions are ever final. With the evidence available at this point, the trainee commits to the family's solutions as best suited to the present situation.

Living with committed relativism and committed to multiple perspectives is the challenge the family trainee must master in this stage. While I have no empirical evidence to support the claim, I suspect that trainees who begin to sense what stage three is about possess more intrinsic interest in family therapy, are more aware of ramifications of therapists' interventions, appear to have greater awareness of ethical issues involved in working with families, have a greater sense of confidence in their skills, and display an attitude that they do not necessarily know what is best for the family in treatment. My hunch is that these trainees possess a dedication to the pursuit

of openness to new understanding--both in the family therapy they conduct and in their orientation to the ethics of how to conduct it.

The Rush to Ethics

1849 saw the Gold Rush stimulated by wishes to strike it rich. In the 1980s and 1990s we seem to be witnessing increased awareness of ethical issues among family psychologists and practitioners in general. No doubt several factors contribute to this increased awareness.

The legal profession. In some states we would now find more attorneys than existed in the entire country in 1849 (some with the aspiration to strike it rich). Texas has over 52,000 attorneys and will admit about 600 more to the bar in 1991. The law schools in Texas plan to admit a full complement of first year law students this Fall. In the current economy, most of the top law firms in Texas have seen cutbacks and will continue laying off legal staff. More attorneys are planning or being compelled to strike out on their own in private practice. Media advertising for legal services continues to increase. I suspect that most of you in the audience could point to similar trends in whatever state you reside.

Increases in the number of attorneys practicing independently and in legal advertisements alerting the public to their rights to possible compensation for all sorts of causes do not go unnoticed by trainees and practitioners of family therapy.

Training programs. Due to increased litigation involving

mental health providers and in part to increased concerns to protect the public, training programs have become more cognizant of including ethics in their curricula. Accreditation standards and credentials review by licensing bodies increasingly place emphasis on the provision of ethics coursework in programs. These courses review ethical codes and guidelines of the profession. Such courses alert trainees to points of contact where ethical and legal perspectives interface. Sensitizing trainees to legal complications in providing services cannot be avoided in teaching such courses.

Implications

The social environment of increased awareness of litigation possibilities and the concern of training programs to provide exposure to ethics may combine very well (or serendipitously) to orient trainees. It may not be too surprising to see trainees approach family therapy with an attitude that they must demonstrate to their supervisors ability to ferret out the "correct" answer in order to pass muster in the program.

Trainees' and practitioners' orientation to ethical concerns has very real consequences. Failing to develop ethically binds and constricts the therapist's efficacy and potential to help the client and the client's family relations.

An illustration of stage one. Let me relate an incident which I think illustrates stage one and its possible consequences. I recall a new trainee playing a taped interview during supervision. The woman confided to the trainee that her

previous therapist had engaged in a sexual relationship with her during therapy. Upon hearing this, the trainee immediately interrupted the client's conversation and with considerable certitude asserted that as the woman's therapist she was ethically obligated to report the incident to the state Board of Examiners of Psychologists. This was the first time the trainee had encountered this issue during therapy. The trainee had learned that the APA Ethical Principles considered therapist-patient sexual relationships unethical. I raised several issues with the trainee. Did the client wish to register a complaint? What would the consequences of filing a complaint be for the client and for her family? Was the incident accurately reported by the client? Despite these questions, the trainee remained committed to reporting the incident and felt unjustly admonished when directed not to pursue such action on her own initiative.

I do not doubt that the trainee was acting in good faith. I do think her level of development could be characterized as falling in Perry's first stage (dualism). She had ferreted out that it was unethical and incorrect for therapists to engage in sexual relationships with their clients and felt she had identified the right course of action. However she had not considered (and seemed unwilling to consider) the ramifications of reporting such an incident for the client, the client's family, or herself.

This brings up a related issue: Clients do not live in a vacuum devoid of ethical and legal sensitivity. I suspect that

clients have, more likely than not, thought about the ramifications for themselves and their family of various courses of action recommended by their therapist. I cannot tell you what the consequences were of my trainee encouraging or discouraging the client to report the sexual incident involving her the prior therapist. The trainee's client failed to return for further treatment after the session in which she confided the incident.

It may not be appropriate to expect that trainees will, must, or necessarily should progress to Perry's stage three (committed relativism) during the time they spend in their training program. Most trainees appear at about level one as they enter family training. There are of course exceptions. Some trainees have experience working in the mental health field before entering formal family training, some have moved beyond stage one as a result of prior beneficial family experiences, and still others are further advanced due to the selectivity of individual differences.

Every trainee moves at his or her own pace. Efforts to expedite progress do not work if the trainee is not prepared to take the next step. Marathon races provide a rough analogy. Simply putting someone in the starting blocks does not assure that the runner will finish the race (much less win the race) if the runner has not been conditioned for the physical stress. Similarly, acting from the ethical orientation of stage three (committed relativism) requires experience that comes with time and working with family issues.

An illustration of stage three. Now let me describe an example which I think illustrates stage three (committed relativism). Therapists of this orientation know few ethical questions in dealing with families have black and white answers. They realize that, at best, our codes and guidelines represent the collective wisdom of the profession and they seem mindful of the predicament pointed out by Van Hoose and Kottler (1977) who wrote:

> If one has a specific responsible rationale for a given therapy intervention, can defend it as justifiable under the circumstances, and the results turn out favorably, then one is in the clear. If, however, the result turns out poorly and somebody complains or files suit, the same action may be construed as irresponsible, unethical, incompetent, or illegal. (pp 42-43)

One of my colleagues worked with a married woman dependent on her husband (or friends) for transportation, even to therapy as she was unable to drive. While fearful of driving, the patient longed desperately for more freedom from dependence including the simple ability to transport herself whenever and wherever she wished. During the course of therapy, the patient struggled with depression and suppressed anger over her dependency. She had abandoned her own self-care for the security of the beneficence her husband provided. After several years of marriage, she was dissatisfied, frightened to take on more self-care, and fearful of risking abandonment or disapproval by her

husband. Her husband was unwilling to enter therapy and satisfied with his wife's dependence on his beneficence. Their relationship allowed him to be king of his castle. During treatment, self transportation emerged as a salient illustration of dependency. Anticipating her husband's reaction with trepidation, the woman passed the written driver's test and obtained a learner's permit. Committed to the patient's own goal, the therapist used some time during several sessions to take the patient out to teach her how to drive in the therapist's own vehicle. The patient eventually had a friend drive her to the license bureau where she successfully completed the driving test for her license.

The patient's husband reacted to his wife's success and step toward greater independence. They did not separate or divorce and the husband still refuses to enter therapy with his wife or on his own. The patient did not terminate treatment but continues to work on other aspects of dependency in her life and family. The present level of resolution is not final, but the patient and the therapist are continuing to adapt to the change in the wife's dependency and deal with the patient's husband.

My colleague in this instance was committed to the goal of the client's increased desire for independence by learning how to drive. Other options (e.g., driving lessons) were not available because of the client's financial constraints, the husband's control, issues of the patient's disclosing knowledge of the extent of her marital dependence, and fears of involving others

where confidentiality could not be assured.

Having the treating therapist give driving lessons is not a course of therapy that I would recommend a trainee in stage one engage in. Opportunity for something to go awry is certainly ample in such an undertaking (e.g., accidents with property damage or bodily injury; increased strain in the marital relationship). One can also imagine ethical issues involving dual relationships. Fortunately nothing went awry in this situation.

Thinking of committed relativism as an ethical orientation should not be mistaken as a general approbation that whatever one does is alright as long as one is not caught. Rather it is recognition that in practicing therapy one takes on risks. The therapist's clear understanding of his/her motives (i.e., why one acts as one does in therapy), willingness to take on responsibility for one's actions, and how the provider goes about the conduct of delivering services is crucial to development of stage three ethical orientation.

References

AAMFT. (1991). AAMFT code of ethics. Washington, DC: Author.

APA. (1981). Specialty guidelines for the delivery of services: clinical psychologists, counseling psychologists, industrial/organizational psychologists, school psychologists. Washington, DC: Author.

APA. (1987). General guidelines for providers of psychological services. American Psychologist, 42, 712-723.

APA. (1990). Ethical principles of psychologists. American Psychologist, 45 390-395.

APA. (1991). Draft of APA ethics code. APA Monitor, 22 (6 June), 32-35.

Belenky, M.F., Clinchy, B.M., Goldberger, N.R., & Tarule, J.M. (1986). Women's ways of knowing: The development of self, voice, and mind. NY: Basic Books.

Greenberg, G.S. (1983). The beginning family therapist and dilemmas in diagnosis. In J.C. Hansen & B.P. Keeney (Eds.) Diagnosis and assessment in family therapy. Rockville, MD: Aspen Publications.

Huber, C.H., & Baruth, L.G. (1987). Ethical, legal, and professional issues in the practice of marriage and family therapy. Columbus, OH: Merrill.

Lakin, M. (1991). Coping with ethical dilemmas in psychotherapy. NY: Pergamon Press.

Perry, W.G. (1970). Forms of intellectual and ethical development in the college years. NY: Holt, Rinehart &

Winston.

Ryder, R., & Hepworth, J. (1990) AAMFT ethical code: "Dual relationships", Journal of Marriage and Family Therapy, 16, 127-132.

Van Hoose, W.H., & Kottler, J. (1977). Ethical and legal issues in counseling and psychotherapy. San Francisco: Jossey Bass.